

**TRANSMITTAL AND NOTICE OF APPROVAL  
OF STATE PLAN MATERIAL  
FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:  
03-019

2. STATE: CT

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
CENTERS FOR MEDICARE AND MEDICAID SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:  
11-01-03

5. TYPE OF STATE PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:  
Section 1905(a) of the Social Security Act and  
42 CFR 447.53-55

7. FEDERAL BUDGET IMPACT:  
a. FFY 2004 (\$ 5,637,500)  
b. FFY 2005 (\$ 6,150,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

pages 1a, 1b, and 3 to Attachment 4.18-A; and  
pages 1 and 3 to Attachment 4.18-C

9. PAGE NUMBER OF THE SUPERSEDED PLAN  
SECTION OR ATTACHMENT (If applicable)

pages 1a, 1b, and 3 to Attachment 4.18-A; and  
pages 1 and 3 to Attachment 4.18-C

10. SUBJECT OF AMENDMENT: The State intends to amend Attachment 4.18-A, sections A and D and Attachment 4.18-C, sections A and D of the State Medicaid Plan pertaining to copayments. The amendment will increase the pharmacy copayment from \$1.00 to \$1.50 for each initial and refilled prescription and over-the-counter drug. In addition, the amendment will impose a \$2.00 copayment on outpatient general hospital services; outpatient psychiatric facility services; clinic services; federally qualified health center services; physician's and dentist's services furnished in an office setting; other medical care or remedial care furnished by individual or group practitioners in an office setting including but not limited to the following: dental hygienists, nurse practitioners, opticians, optometrists, physician assistants, and nurse midwife services. The copayment will be charged on each client visit to a provider even if there are multiple visits with the same provider on a single date of service.

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:  
Comments, if any, to follow.

*Connecticut (03-019)*  
*approved: 12/30/03*  
*effective: 11/01/03*

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Michael P. Starkowski

14. TITLE: Deputy Commissioner

15. DATE SUBMITTED:  
October 29, 2003

16. RETURN TO:

State of Connecticut  
Department of Social Services - 11<sup>th</sup> floor  
25 Sigourney Street  
Hartford, CT 06106-5033  
Attention: Donald Iodice

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: November 4, 2003

18. DATE APPROVED: December 30, 2003

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
November 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:  
Bruce D. Greenstein

22. TITLE: Associate Regional Administrator, DMCH

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CONNECTICUT

- A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) [through (5) and (7)], (3), (4), (7), (13) through (16), (19) and (24) of the Act:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
Pharmacy prescription drugs, over-the-counter drugs and refills.			X	A copayment of [\$1.00] <u>\$1.50</u> is imposed for pharmacy prescriptions. The nominal copayment is charged on each initial and refilled prescription and over-the-counter drug. The nominal copayment is based on the agency's average amount allowed [of \$31.95] per prescription and over-the-counter drug filled. The details of the calculation of the average [is] <u>are</u> attached.

OFFICIAL

TN No. 03-019  
Supersedes  
TN No. 97-007

Approval date: 12/30/03

Effective Date: 11/01/03  
HCFA ID: 0053C/0061E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CONNECTICUT

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
Outpatient general hospital services; outpatient psychiatric facility services; clinic services; federally qualified health center services; physician's and dentist's services furnished in an office setting; other medical care or remedial care furnished by individual or group practitioners in an office setting including but not limited to the following: dental hygienists, nurse practitioners, opticians, optometrists, physician assistants, and nurse midwife services. Non-inpatient services excluded from the copayment requirement include but are not limited to home health agency services; medical equipment, devices and supplies; independent laboratory; medical transportation; school based child health; family planning services and supplies; emergency services; personal care assistants; dialysis clinics; detoxification services; targeted case management; acquired brain injury services; 1915(c) waiver services; and cross-over claims;			X	A copayment of \$2.00 is imposed for each of the listed medical services. The nominal copayment is charged on each client visit to a provider even if there are multiple visits with the same provider on a single date of service. The nominal copayment is based on the agency's average amount allowed per visit per category of service. The details of the calculation of the averages are attached.

OFFICIAL

TN No. 03-019  
Supersedes  
TN No. NEW

Approval date: 12/30/03

Effective Date: 11/01/03  
HCFA ID: 0053C/0061E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Connecticut

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**D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b) are described below:**

The exclusion shall be implemented under State statute provisions and promulgated under the State's Administrative Procedures Act as a part of the Medical Assistance Program.

The provider shall insert a Location Code in a designated field on the Pharmacy Claim Form for all recipients who are excluded from the copayment requirement. By inserting the appropriate exclusion code on the claim form, no copayment will be deducted from the maximum amount allowed for the prescription or over-the-counter drug. Determination that the providers correctly meet the exclusion requirements will be accomplished through the post payment review process in accordance with 42 CFR 456.23.

The exclusion shall be automatically applied to eligible non-pharmacy medical services in the Medicaid Management Information System and by managed care organizations responsible for administering Connecticut Medicaid services under a 1915(b) waiver.

**E. Cumulative maximums on charges:**

**/ X / State policy does not provide for cumulative maximums.**

**/ / Cumulative maximums have been established as described below:**

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CONNECTICUT

B. The following charges are imposed on the medically needed for services:

Service	Type of Charge		Amount and Basis for Determination
	Deduct.	Copay	

See Attachment 4.18-A, Pages 1a-1b.  
Charges for the medically needy  
are the same as for the  
categorically needy.

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**/ / Cumulative maximums have been established as described below:**

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